FREDERICK CO. GOV'T HEALTH ENROLLMENT

☐ CIGNA OAP In-network
☐ CIGNA OpenAccessPlus
☐ CIGNA OAP HighDeductible

☐ New Enrollment
☐ Dependent Addition
☐ Cancel Coverage-All
☐ Cancel Coverage-Deps
☐ Name/Address Change
☐ Open Enrollment Change
☐ COBRA

A. OTHER MEDICAL COVERAGE INFORMATION

Will you or your dependents have any other medical coverage in force at the same time as this plan? ☐ Yes ☐ No If Yes, list plan details below.

Insurance Company Name	Coverage Start Date	Coverage Stop Date

Coverage type: ☐ Group Policy ☐ Individual Policy ☐ Medicare/ Medicaid

B. MEMBER INFORMATION

Social Security Number	Group Policy Number	Effective Date	Birth Date	Sex
	3334606			

Last Name	First Name	M.I.	Home Phone Number	Email Address

Street Address | City | State | Zip

Work Phone Number	Department	Date Employed	Marital Status: ☐ Married ☐ Single

C. DEPENDENT INFORMATION

Action Type	Last Name First Name M.I.	Sex	Birthdate	Relationship**	Disabled?
☐ Enroll ☐ Cancel ☐ Change	Social Security Number:				☐ Yes ☐ No
☐ Enroll ☐ Cancel ☐ Change	Social Security Number:				☐ Yes ☐ No
☐ Enroll ☐ Cancel ☐ Change	Social Security Number:				☐ Yes ☐ No
☐ Enroll ☐ Cancel ☐ Change	Social Security Number:				☐ Yes ☐ No
☐ Enroll ☐ Cancel ☐ Change	Social Security Number:				☐ Yes ☐ No

** For court ordered dependent, legal documentation must be attached. If dependant does not reside with eligible employee, please provide address on separate sheet.

D. CONDITIONS OF ENROLLMENT

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY OR ANY OTHER PERSON. PENALTIES INCLUDE INPRISONMENT AND/OR FINES. IN ADDITION, THE INSURANCE COMPANY MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

I confirm that the information I have provided on this form is complete and accurate.

I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my physician or me, or medical expenses which I have incurred, may not be covered by my health benefit plan.

I acknowledge that I have received the "Important Information" statement, which is included on the back of this form.

Employee Signature _____ Date _____

Employer Representative _____ Date _____

IMPORTANT INFORMATION

In order to make choices about your health care coverage and treatment, it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete and you are urged to contact the insurance company if the information in your Certificate of Coverage and other materials do not answer your questions.
Further information is available at www.myCIGNA.com, or through your employer.

1. The insurance company does not provide medical services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:
   - They make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.
   - They do not decide what care you need or will receive. You and your physician make those decisions.

2. At CIGNA HealthCare, they are committed to maintaining the confidentiality of members' health information. They have established policies and safeguards to protect oral, written and electronic information across their organization. They will not use or disclose your confidential information for any purpose other than the purposes permitted by the HIPAA Privacy Rule without your written authorization. For example, they will not supply confidential information to another company for its marketing purposes or to a potential employer with whom you are seeking employment unless you authorize it.

3. Physicians and other providers in plan networks are independent contractors and are not the insurance company's employees or agents. The insurance company does not control nor do they have a right to control your physician's treatment plan.

4. If you are declining enrollment in a health insurance plan because you are covered by another health insurance plan, you may be able to enroll yourself and dependents at a later date if you or your dependents lose eligibility for that other coverage. However, **you must request enrollment from your employer within 30 days after the other coverage ends**.

5. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, or lose dependents as a result of death or divorce, you may enroll or disenroll the affected people from coverage, but **only if you request the change within 30 days of the event** that triggered the change. You also have the opportunity to make changes to your health insurance during the annual open enrollment period. Contact your employer benefits representative for additional information about making changes to coverage.

6. I understand that the Certificate of Coverage and other documents, notices and communications regarding my health benefit plan may be transmitted electronically.

7. I understand that I have a continuing obligation to report changes in enrollment status (e.g. name and address changes, dependents reaching an age when they lose dependent status) to my employer benefits representative after I sign the enrollment form and during the time I am enrolled for coverage.

8. Your health insurance is offered as a benefit from your employer. By enrolling for the benefit, you authorize any required premium contributions to be deducted from earnings, or agree to pay your portion during any periods when you are covered but not receiving earnings. Failure to pay your portion may result in your coverage being terminated.